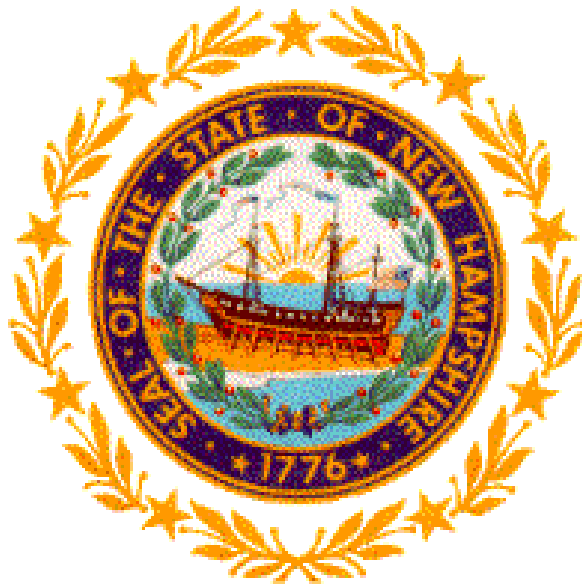


**STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF COMMUNITY BASED CARE SERVICES
BUREAU OF BEHAVIORAL HEALTH**

**COMMUNITY MENTAL HEALTH PROGRAM
REAPPROVAL REPORT**



**THE MENTAL HEALTH CENTER OF
GREATER MANCHESTER**

MAY 21, 2010

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF COMMUNITY BASED CARE SERVICES
BUREAU OF BEHAVIORAL HEALTH

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STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF COMMUNITY BASED CARE SERVICES
BUREAU OF BEHAVIORAL HEALTH

ACRONYMS AND DEFINITIONS

Acronyms

BBH
BOD
CEO
CFO
CMHP
CSP
DCBCS
DHHS
EBP
ED
ES
FSS
GOI
GSIL
IOD
IMR
ISP
IT
MHCGM
MOU
NAMI-NH
NHH
NHVR
PRC
OCFA
OCLS
OIII
PSA
QI
REAP
SFY
SURS
SE
TCM
UNH

Definitions

Bureau of Behavioral Health
Board of Directors
Chief Executive Officer
Chief Financial Officer
Community Mental Health Program
Community Support Program
Division of Community Based Care Services
Department of Health and Human Services
Evidence Based Practice
Executive Director
Emergency Service
Functional Support Services
General Organizational Index
Granite State Independent Living
Institute on Disability
Illness Management and Recovery
Individual Service Plan
Information Technology
Mental Health Center of Greater Manchester
Memorandum of Understanding
National Alliance for the Mentally Ill
New Hampshire Hospital
New Hampshire Vocational Rehabilitation
Dartmouth Psychiatric Research Center
Office of Consumer and Family Affairs
Office of Client and Legal Services
Office of Improvement, Integrity and Information
Peer Support Agency
Quality Improvement
Referral, Education, Assistance and Prevention
State Fiscal Year
Surveillance Utilization Review Subsystems
Supported Employment
Targeted Case Management Services
University of New Hampshire

EXECUTIVE SUMMARY

In accordance with State of New Hampshire Administrative Rule He-403 Approval and Reapproval of Community Mental Health Programs, reviews of community mental health programs (CMHP) occur upon application and thereafter every five years. The purpose of He-403 is to define the criteria and procedures for approval and operation of community mental health programs. A reapproval review of The Mental Health Center of Greater Manchester (MHCGM) in Manchester, NH occurred on January 4-8, 2010, and also included a Board of Directors (BOD) Meeting on March 23, 2010. The review team included staffs from the Department of Health and Human Services (DHHS), the Bureau of Behavioral Health (BBH) and the Office of Improvement, Integrity and Information (OIII).

MHCGM submitted an application for reapproval as a CMHP that included:

- A letter requesting Reapproval;
- A description of all programs and services operated and their locations;
- The current strategic plan;
- A comprehensive listing of critical unmet service needs within the region;
- Assurances of compliance with applicable federal and state laws and rules;
- The Mission Statement of the organization;
- A current Board of Director list with terms of office and the towns represented;
- The By-Laws;
- The BOD meeting minutes for Calendar year 2009;
- The current organizational chart;
- Various job descriptions;
- The current Quality Improvement Plan;
- The current Disaster Response Plan.

Additional sources of information prior to the site visit included:

- The New Hampshire Public Mental Health Consumer Survey Project (December 2008);
- Evidence Based Practice (EBP) Fidelity Reviews for Illness Management and Recovery (IMR) and Supported Employment (SE);
- BBH QI and Compliance Reports Five Year Trends;
- BBH Community Mental Health System Annual Report of Financial Condition for Fiscal Year 2009 with Five Year Financial Trend Analysis;
- A Public Notice published in local newspapers soliciting feedback regard the CMHP;
- A letter to MHCGM constituents soliciting feedback regarding the CMHP;
- Staff surveys soliciting information from MHCGM staff regarding training, supervision, services and CMHP operations.

The site visit to MHCGM included:

- Review of additional documentation including: orientation materials for new BOD members, the Policy and Procedure Manual, Interagency Agreements, and Memoranda of Understanding (MOU), and a sample of personnel files;
- Interviews with the BOD, the CMHP Management Team, the Chief Financial Officer (CFO), Human Resources Director.

The findings from the review are detailed in the following focus areas: Governance; Services and Programs, Human Resources; Policy; Financial; Quality Improvement and Compliance; Consumer and Family Satisfaction. The structure of the reports includes the Administrative Rule Requirement, team observations, team recommendations, and a text area for the CMHP response.

The following is a summary of the recommendations included in the report:

- Clarify the process for the approval of agency policies;
- A copy of the current annual evaluation for all staff including the CEO must be kept in the personnel files;
- The Disaster Response Plan be reviewed and approved by the BOD or their designee;
- Explore ways to share information with the BOD regarding ongoing programmatic efforts and accomplishments including multicultural and other initiatives;
- IMR outcome information should be shared with practitioners;
- Actively market the SE program to the eligible population in an effort to increase the penetration rate;
- Develop a standardized approach to ensure that consumers have access to current, accurate, comprehensive and individualized benefits and work incentives information;
- Explore opportunities for collaboration with the local peer support agency;
- All targeted case management service descriptions should focus on the core activities of assessment, referral and monitoring;
- The policy manual must address all policy requirements outlined in He-M 403;
- Develop policies regarding the provision of or the referral to child and adolescent sexual offender assessment and treatment;
- Update and or delete policies that include references to discontinued services such as Mental Illness Management Services;
- Monitor any growth in Accounts Receivable older than 212 days;
- Any receivables that are deemed uncollectible should be written off;
- The NH Public Mental Health Consumer Survey Project be shared with the BOD and utilized in planning activities;
- The BBH QI and Compliance Reports be shared with the BOD and utilized in planning activities.

PURPOSE, SCOPE AND METHODOLOGY

Staff from the NH DHHS, BBH and OIII, conducted an on-site review of MHCGM on January 4-8, 2010, and attended a BOD Meeting on March 23, 2010. Members of the review team included Karen Orsini, Michael Kelly, Joy Cadarette, Michele Harlan, Ann Driscoll, and Alan Harris. The review was conducted as part of a comprehensive reapproval process that occurs every five years in accordance with Administrative Rule He-M 403.

A brief meeting was held to introduce the team members and discuss the scope and purpose of the review. In an effort to reduce the administrative demands on agencies, the annual QI and Compliance Review was conducted during the reapproval visit. Please note that the results of the QI and Compliance Review are not fully included in this document and have been sent as a separate report. Two structured interviews were conducted as part of the site visit, one with the Management Team, and another with the BOD.

A brief exit meeting was conducted on January 8, 2010, and was open to all staff. Preliminary findings were reviewed and discussed at that time.

Prior to the visit, members of the team reviewed the following documents: (Available at BBH)

- Letter of application from MHCGM requesting reapproval as a community mental health center;
- Critical unmet service needs within the region;
- Assurances of compliance with applicable federal and state laws and rules;
- Description of all programs and services operated and their locations;
- Current strategic plan;
- Mission Statement of the organization;
- Current Board of Director list with terms of office and the towns represented;
- Board of Director By-Laws;
- Board of Director meeting minutes for calendar year 2008;
- Current organizational chart;
- Job descriptions for Chief Executive Officer, Medical Director, Children's Coordinator Older Adults Coordinator and Case Manager;
- Current Quality Improvement Plan;
- Current Disaster Response Plan;
- The MHCGM contract with BBH;
- Results of SFY 2007 Adult and Child QI and Compliance Review;
- The findings of the previous reapproval report;
- Fiscal manual;
- Billing manual;
- Detailed aged accounts receivable listings for SFY 2007 and SFY 2008;
- Job Descriptions for all accounting and billing staff.

The onsite review at MHCGM included an examination of the following:

- Board of Director policies;
- Orientation materials for new Board of Director members;
- Board of Director approved Policy and Procedure Manual;
- MOUs or Interagency Agreements including those with but not limited to:
 - Peer Support Agencies;

- Housing Authorities;
- Homeless Shelters;
- Substance Use Disorder Programs;
- Area Agencies;
- Vocational Rehabilitation;
- Division of Children, Youth and Families;
- Other Human Services Agencies;
- Adult and children's Criminal Justice organizations;
- NAMI-NH.
- Policies and procedures for:
 - Clients Rights;
 - Complaint Process/Investigations.
- Management Team Minutes for calendar year 2008;
- Several personnel files including those for:
 - Chief Executive Officer;
 - Medical Director.

A Public Notice of the CMHP's application for Reapproval was published in local newspapers distributed in the region in an effort to solicit comments from the communities served.

In addition, BBH sent letters soliciting feedback from agencies within the region with which MHCGM conducts business.

Employee surveys were sent to MHCGM staff during the review process soliciting anonymous feedback regarding various issues relevant to employee satisfaction. The results are summarized in this report.

Information was gathered from a variety of additional sources from different times within the previous approval period. Observations and recommendations are based on the information published at that time. Sources of information include:

- The New Hampshire Public Mental Health Consumer Survey Project (December 2008);
- EBP Reviews for IMR and SE;
- BBH QI and Compliance Reports Five Year Trends;
- BBH Community Mental Health System Annual Report of Financial Condition for Fiscal Year 2009 with Five Year Financial Trend Analysis.

The findings from the review are detailed in the following focus areas; Governance; Services and Programs, Human Resources; Policy; Financial; Quality Improvement and Compliance; Consumer and Family Satisfaction. The structure of the reports includes the Administrative Rule Requirement, team observations, team recommendations and a text area for the CMHP response.

AGENCY OVERVIEW

Founded in 1960, The Mental Health Center of Greater Manchester (MHCGM) is a non-profit community-based, mental health organization serving the needs of individuals and families in New Hampshire's largest city (Manchester) and surrounding towns. MHCGM has grown to more than 330 employees and eight service locations.

The MHCGM mission statement is:

“To provide an accessible, comprehensive, integrated, evidence-based system of mental health services that empowers individuals to achieve recovery and serves to promote personal and community wellness.”

MHCGM provides a comprehensive array of evidenced based, community mental health services for children, adults, and older adults. These services include: intake assessment services; psychiatric diagnostic and medication services; psychiatric emergency services; Acute Psychiatric Residential Treatment Programs; case management services; individual, group and family psychotherapy; evidenced based practices including SE and IMR; services for persons with co-occurring disorders; functional support services; residential services; respite care; outreach services; Naturopathic Medicine; Research and Development; Memory Wellness; Mindful Wellness; education and support to families; and consultation services.

MHCGM is one of the largest off-campus training sites for residents in psychiatry from Dartmouth Medical School. Most of MHCGM's medical staff is on the Dartmouth faculty. In recent years, MHCGM has provided consultation and training to representatives from 27 states and 10 foreign countries including Japan, Australia, the Netherlands, Canada, and the United Kingdom.

MHCGM has a website (<http://www.mhcg.org/index.shtml>) which includes information on service programs, consumer and family information, continuing education, mental wellness resources, fundraising, web links, and other resources.

The towns served by MHCGM include:

Auburn
Bedford

Candia
Goffstown

Hooksett
Londonderry

Manchester
New Boston

SECTION I. GOVERNANCE

Administrative Rule He-M 403.06 defines a CMHP as an incorporated nonprofit program operated for the purpose of planning, establishing and administering an array of community-based mental health services.

This administrative rule requires that a CMHP shall have an established plan for governance. The plan for governance shall include a BOD who has responsibility for the entire management, and control of the property and affairs of the corporation. The BOD shall have the powers usually vested in a BOD of a nonprofit corporation. The responsibilities and powers shall be stated in a set of bylaws maintained by the BOD.

A CMHP BOD shall establish policies for the governance and administration of the CMHP. Policies shall be developed to ensure efficient and effective operation of the CMHP and adherence to all state and federal requirements.

Each BOD shall establish and document an orientation process for educating new board members. The orientation shall include information regarding the regional and state mental health system, the principles of recovery and family support, and the fiduciary responsibilities of board membership.

At the time of the review, MHCGM was in substantial compliance with all the requirements referenced above.

REQUIREMENT: He-M 403.05 (e) A CMHP Board of Directors shall establish policies for the governance and administration of the CMHP and all services through contracts with the CMHP. Policies shall be developed to ensure efficient and effective operation of the CMHP-administered service delivery system and adherence to requirements of federal funding sources and rules and contracts established by the department.

OBSERVATION I-A:

There is some conflicting information regarding the approval process for agency policies. The BOD reported that they approve all agency policies. Policy # 1.07.04 “Policy and Procedure Development” states that the Senior Leadership Team approves all policies. Individual policies indicate approval by the CEO at the top of the first page.

RECOMMENDATION I-A:

Clarify the process for the approval of agency policies. For example the BOD may approve a policy that designates the Senior Leadership Team or the CEO as responsible for the final approval of agency policies.

CMHP RESPONSE I-A:

REQUIREMENT: He-M 403.05 (h) (3) The Senior Executive Officer shall be evaluated annually by the CMHP Board of Directors/Advisory Board to ensure that services are provided in accordance with the performance expectations approved by the board, based on the Department’s rules and contract provisions.

OBSERVATION I-B:

The most recent evaluation on file for the CEO was dated June 2008.

RECOMMENDATION I-B:

A copy of the current annual evaluation for all staff, including the CEO, must be kept in the personnel files.

CMHP RESPONSE I-B:

REQUIREMENT: He-M 403.03 (b) (1) A CMHP Board of Directors shall have responsibility for the entire management and control of the property and affairs of the corporation and shall have the powers usually vested in the Board of Directors of a nonprofit corporation, except as regulated herein, and such responsibility and powers shall be stated in a set of bylaws maintained by the CMHP Board.

He-M 403.06 (a) and (a) (7) A CMHP shall provide the following, either directly or through a contractual relationship: Planning, coordination, and implementation of a regional mental health disaster response plan.

OBSERVATION I-C:

The Disaster Response Plan included no signatures indicating review and approval.

RECOMMENDATION I-C:

The Disaster Response Plan be reviewed and approved by the BOD or their designee.

CMHP RESPONSE I-C:

REQUIREMENT: He-M 403.06 (l) A CMHP shall provide services that are responsive to the particular needs of members of minority communities within the region.

OBSERVATION I-D:

MHCGM has always been and remains a leader in the NH community mental health system regarding multicultural initiatives. This leadership currently includes representation from the NH Minority Health Coalition on the MHCGM BOD.

The BOD clearly had multiple strengths including a broad skills and knowledge base as well as representation from across the communities served. Knowledge of programmatic accomplishments such as current multicultural initiatives was less apparent.

RECOMMENDATIONS I -D:

MHCGM explore ways to share information regarding ongoing programmatic efforts and accomplishments including multicultural and other initiatives.

CMHP RESPONSE I-D:

SECTION II: SERVICES AND PROGRAMS

Administrative Rule He-M 403.06 (a) through (f) requires that a CMHP provide a comprehensive array of community based mental health services. The priority populations include children, adults and older adults meeting BBH eligibility criteria per Administrative Rule He-M 401.

BBH has prioritized EBPs, specifically IMR and SE. CMHPs are also required to offer Targeted Case Management to the BBH eligible population. These requirements are specified in Administrative Rule He-M 426.

Emergency mental health services and intake services are required to be available to the general population. Emergency mental health services are also required to be available 24 hours a day, seven days a week. These requirements are specified in Administrative Rule He-M 403.

The CMHP must provide outreach services to people who are homeless. The CMHP must also collaborate with state and local housing agencies to promote access to housing for persons with mental illness.

Assessment, service planning and monitoring activities are required for all services per Administrative Rules He-M 401 and He-M 408.

Each CMHP is required to have a Disaster Response Plan on file at BBH per Administrative Rule He-M 403.

At the time of the review, MHCGM was in substantial compliance with all the requirements referenced above.

REQUIREMENTS:

He-M 403.05 (d) (3) Enhance the capacity of consumers to manage the symptoms of their mental illness and to foster the process of recovery to the greatest extent possible.

He-M 403.06 (a) (15) A CMHP shall provide the following, either directly or through a contractual relationship: Mental illness self-management and Rehabilitation Services (IROS) pursuant to He-M 426, including those services provided in community settings such as residences and places of employment.

ADDITIONAL INFORMATION SOURCE:

IMR Fidelity Review Reports – The General Organizational Index (GOI) Penetration Review Section. The GOI review is intended to measure the structural components that exist in an agency that will facilitate the delivery of EBPs such as IMR. The anchor points on the GOI scale are defined for each individual item, and can be roughly thought of as ranging from a one (1) corresponding to not implemented in this program at this time, to a five (5) indicating that the item is fully implemented. Only those sections with a score of one (1) or two (2) at the time of the review are referenced below. Recommendations are based on the findings from that review period.

Outcome Monitoring	1	2	3	4	5
Supervisors/program leaders monitor the outcomes for EBP consumers every 3 months and share the data with EBP practitioners. Monitoring involves a standardized approach to assessing a key outcome <i>related to the EBP</i> , e.g., psychiatric admissions, substance abuse treatment scale, or employment rate.	No outcome monitoring occurs.	Outcome monitoring occurs at least once a year, but results are not shared with practitioners.	Standardized outcome monitoring occurs at least once a year and results are shared with practitioners.	Standardized outcome monitoring occurs at least twice a year and results are shared with practitioners.	Standardized outcome monitoring occurs quarterly and results are shared with EBP practitioners.

OBSERVATION II-A:

Outcome information has been collected at least annually but not shared with the IMR staff.

RECOMMENDATION II-A:

Outcome information should be shared with practitioners.

CMHP RESPONSE II-A:

REQUIREMENTS:

He-M 403.06 (a) (5) a. Provide supports and opportunities for consumers to succeed at competitive employment, higher education and community volunteer activities.

He-M 403.06 (a) (5) b. 1-3. Vocational Assessment and Service Planning; competitive employment and supported work placements; and employment counseling and supervision.

ADDITIONAL INFORMATION SOURCE:

SE Fidelity Review Reports - The General Organizational Index (GOI) Penetration Review Section. SE fidelity reviews are conducted in order to determine the level of implementation and adherence to the evidenced based practice model of the CMHPs SE program. A SE fidelity score was determined following the review.

The anchor points on the GOI scale are defined for each individual item, and can be roughly thought of as ranging from a one (1) no implementation, to a five (5) full implementation. Only those sections with a score of one (1) or two (2) at the time of the review are referenced below. Recommendations are based on the findings from that review period.

Penetration.	1	2	3	4	5
The maximum number of eligible consumers are served by the EBP, as defined by the ratio: <u># Consumers receiving EBP</u> <u># Consumers eligible for EBP</u>	Ratio ≤ .20	Ratio between .21 and .40	Ratio between .41 and .60	Ratio between .61 and .80	Ratio > .80

Penetration is defined as the percentage of consumers (age 18-59) who have access to SE as measured against the total number of consumers who could benefit from SE. The number of consumers with severe mental illness who would be eligible and willing to use SE services is shown by research to be 60% of consumers at any given time. Numerically, for the penetration rate for SE is defined by:

$$\frac{\text{\# Of consumers receiving SE (age 18-59)}}{(\text{\# Of consumers eligible for SE (age 18-59)} * .60)}$$

$$\frac{186 \text{ consumers receiving SE services currently}}{600 = (1000 \text{ eligible} \times .60)} = .31 \text{ ratio}$$

OBSERVATION II-B:

Research shows that 60% of consumers voice a desire to work over the course of any given year. At the time of the fidelity review, the ratio of # served to # eligible was between .21 and .40. This results in a rating of two out of five.

RECOMMENDATION II-B:

MHCGM is encouraged to actively market the S.E. program to the eligible population in an effort to increase the penetration rate.

CMHP RESPONSE II-B:

Please note that the structure of this section of the Reapproval Report varies to reflect the structure of the original SE fidelity report. Specifically, the requirements, ratings and observations are presented as a single section followed by several recommendations.

SERVICES	RATING
Work Incentive Planning: All clients are offered assistance in obtaining comprehensive, individualized work incentives planning before starting a new job and assistance accessing work incentives planning thereafter when making decisions about changes in work hours and pay. Work incentives' planning includes SSA benefits, medical benefits, medication subsidies, housing subsidies, food stamps, spouse and dependent children benefits, past job retirement benefits and any other source of income. Clients are provided information and assistance about reporting earnings to SSA, housing programs, VA programs, etc., depending on the person's benefits.	2

OBSERVATION II-C:

There was no documentation in the records reviewed regarding work incentive planning. Consumers do not appear to have access to individualized work incentive planning that affords them the opportunity to make fully informed choices regarding their benefits.

RECOMMENDATIONS II-C:

Develop a standardized approach to ensure that consumers have access to current, accurate, comprehensive and individualized benefits, and work incentives information.

CMHP RESPONSE II-C:

REQUIREMENT: He-M 403.05 (d) (2) A CMHP shall ensure that all programs and services it administers builds upon consumers' strengths and mitigate, as much as possible, the disabling effects of mental illness; and He-M 408.08 (b) (1) The ISP shall be a comprehensive document which identifies consumer strengths:

OBSERVATION II-D:

Data from the FY09 BBH quality improvement and compliance review reflect 7% of adult records and 4% of child individual service plans identified consumer strengths. BBH requires a corrective action response for any item below 75% compliance. It is noted that strengths are found elsewhere in the clinical records.

RECOMMENDATION II-D:

MHCGM should continue corrective action to improve compliance with this requirement.

CMHP RESPONSE II-D:

REQUIREMENT: He-M 403.06 (a) (13) Consultation, as requested, and support to consumer-operated programs to promote the development of consumer self-help/peer support.

OBSERVATION II-E:

The relationship with the local peer support program has varied overtime, including participating in a Mental Health Leadership Collaborative.

RECOMMENDATIONS II-E:

MHCGM is encouraged to explore opportunities for collaboration with the local peer support agency.

CMHP RESPONSE II-E:

REQUIREMENT: He-M 403.06 (a) A CMHP shall provide the following, either directly or through a contractual relationship: (2) Case Management pursuant to He-M 426.15.

OBSERVATION II-F:

Though program and team descriptions were included in the application and on the website, these did not include a clear description of core targeted case management services (assessment,

referral, and monitoring). In addition, the services identified in case management job descriptions are more broadly defined, and included activities outside the core services of assessment, referral, and monitoring.

RECOMMENDATION II-F:

It is recommended that all targeted case management service descriptions focus on the core activities of assessment, referral, and monitoring.

CMHP RESPONSE II-F:

REQUIREMENT: He-M 403.06 (d) (9) Services provided to children shall include Sexual Offender Assessments and Treatment.

OBSERVATION II-G:

MHCGM does not provide these services.

RECOMMENDATION II-G:

Develop policies regarding the provision of or the referral to child and adolescent sexual offender assessment and treatment.

CMHP RESPONSE II-G:

SECTION III: HUMAN RESOURCES

The CMHP is responsible for determining the qualifications and competencies for staff based upon its mission, populations served and the treatment and services provided. An organization's personnel policies define what the agency can expect from its employees, and the employees can expect from the agency.

The BOD is responsible to review and approve the CMHP's written personnel policies. The policies should be reviewed on a regular basis to incorporate new legal requirements and organizational needs. Every employee should review a copy of the policies.

The BBH team reviewed a sample of MHCGM personnel records to assure compliance with Administrative Rule He-M 403.05 (g) through (i) and He-M 403.07 (a) through (e) including current licensure resumes, training documentation, and background checks.

In addition, an anonymous survey was distributed to MHCGM staff at the time of the review. A total of 210 surveys were distributed and 72 were returned for a response rate of 34%. The focus of the survey were questions regarding training, recovery orientation of the agency, consumer focus, agency responsiveness to consumer, impact of funding restrictions, and supervision. Included below is a summary of responses in both narrative and aggregate form.

At the time of the review MHCGM was in substantial compliance with all the requirements referenced above.

REQUIREMENT: The table below consolidates the findings regarding the requirements in He-M 403.07 (b) through (e) pertaining to documentation found in personnel files.

OBSERVATIONS III-A:

MHCGM HUMAN RESOURCES TABLE												
He-M	Requirement	Personnel Files										
		1	2	3	4	5	6	7	8	9	10	% Compliance
He-M 403.07 (b)	Criminal background checks	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	100%
He-M 403.07 (b)	OIG sanctioned provider check	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	100%
He-M 403.07 (b)	DMV check	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
He-M 403.07 (c)	Annual performance review	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	90%
He-M 403.07 (d)	Staff development plans	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	90%
He-M 403.07 (e)	Orientation training	N/A	N/A	N/A	Y	Y	Y	Y	Y	Y	Y	100%
He-M 403.07 (e) (1)	Does Orientation include the Local and State MH System including Peer and Family Support	N/A	N/A	N/A	Y	Y	Y	Y	Y	Y	Y	100%

MHCGM HUMAN RESOURCES TABLE continued												
He-M	Requirement	Personnel Files										
		1	2	3	4	5	6	7	8	9	10	% Compliance
He-M 403.07 (e) (2)	Does Orientation include an overview of mental illness and current MH practices	N/A	N/A	N/A	Y	Y	Y	Y	Y	Y	Y	100%
He-M 403.07 (e) (3)	Does Orientation include Applicable He-M Administrative Rules	N/A	N/A	N/A	Y	Y	Y	Y	Y	Y	Y	100%
He-M 403.07 (e) (4)	Does Orientation include accessing the local generic service delivery system	N/A	N/A	N/A	Y	Y	Y	Y	Y	Y	Y	100%
He-M 403.07 (e) (5)	Does Orientation include Client Rights training	N/A	N/A	N/A	Y	Y	Y	Y	Y	Y	Y	100%

* Please note that “N/As” in the table above are due to staff hired before the current requirement became effective or for staff who do not transport consumers”.

RECOMMENDATIONS III-A:

All personnel files be monitored for completeness including annual evaluations for the CEO per He-M 403.07 (c).

CMHP RESPONSE III-A:

**THE MENTAL HEALTH CENTER OF GREATER MANCHESTER
REGION VII**

**STAFF SURVEY RESULTS
2009**

As part of the Reapproval process, BBH requested that a CMHP staff survey be distributed. The surveys are completed, returned in a sealed envelope and the results compiled for inclusion in this report. The results of the survey are outlined below for consideration by MHCGM.

1. Does your agency provide job-related training?

<u>Yes</u>	<u>No</u>	<u>No Answer</u>
170/179	1/179	8/179
95%	1%	4%

a. How would you rate your agency's staff training effects?

<u>Poor</u>	<u>Fair</u>	<u>Good</u>	<u>No Answer</u>
1/179	10/179	168/179	0/179
1%	6%	94%	0%

b. How responsive is your agency to your training requests? (Give examples)

<u>Poor</u>	<u>Fair</u>	<u>Good</u>	<u>No Answer</u>
1/179	26/179	143/179	9/179
1%	15%	80%	5%

1. Does your agency provide job-related training?

No comments.

a. How would you rate your agency's staff training effects?

No comments.

b. How responsive is your agency to your training requests? (Give examples)

1. We offer monthly CEU courses, in addition to DBT training for staff 2 times annually.
2. Strongly support staff and educational activities. Fantastic, in-house training opportunities – in-service education/training. On-line courses – Essential Learning Program as well as support to attend outside training/conferences to meet continuing education requirements to maintain licensure and certification.
3. I am a new employee (less than 3 months) but will sign up soon for a training – have attended 2-one hour lunchtime training sessions that were useful.
4. The agency offers a variety and extensive trainings that provide CEUs/CMEs, e.g. Grand Rounds, Dartmouth Grand Rounds, Lunch Box Lectures, EBP trainings (TMR, IDDT, SE, MOX National, DBT) to name a just a few. Each year staff and board members are surveyed to elicit topics of interest. In addition, board members receive a brief training on topics of their choice at

the beginning of each board meeting. We also have access to Essential Learning – web-based and an extensive resource library.

5. Training requests have all been fulfilled, including JDDT, Motivational Interviewing, and Stages of Change.
6. I am provided with funds to attend workshops outside the agency.
7. I told them I would like access training. The following Tuesday there was a training.
8. Every staff person has an allotment, for example: Staff Development; and we do many in-house training according to needs.
9. Anytime training is requested the supervisor goes out of their way to approve it and find coverage so we can attend.
10. Always available for questions, teaching and resources are available.
11. Essential learning – keeping current with evidenced based practices.
12. Extensive DBT training, Stages of Change, Motivational Interviewing, Regular Grand Rounds, and Lunchbox Lectures.
13. Not enough for non-clinical staff – training just to get hours in is not productive.
14. Supervisors work with you to find available online trainings for a given topic or contact continuing education department for possibilities if none exist – so we are able to do the best job for our clients. As far as job-related training for clients – I do not know what is offered as I work in a support staff position.
15. When I have asked for a specific training, I received it.
16. They ask for input.
17. Always open to new training events.
18. Part-timers and per diem clinicians receive no funding for attending trainings.
19. They do arrange requested topics.
20. Our supervisor has given our team trainings we have asked for.
21. Departmentally, the administrative staff will honor suggestions. Agency-wide surveys are sent out for desires for trainings.
22. Coverage issues are a problem to attend trainings.
23. Upon request, they research topics for presentations, DVDs or Webinar.
24. Continuous DBT trainings is an example.
25. Provide excellent opportunities by internal offerings and essential learning.
26. When asked for in-services on specific medications, training was provided.
27. When CPR is in need of being updated – class is made available.
28. HR has always provided me access to relevant trainings I have submitted to attend.
29. I have not requested specific trainings.
30. Exceptional staff Continuing Ed Program. Asks for ideas for future trainings on each eval and surveys staff for ideas.
31. Will pay the first \$150.00 yearly.
32. We are surveyed for topics at least one time per year. Requests during group support are done as part of education component 2 times per month. Study groups (for DBT monthly).
33. Required trainings upon hire – specific to job. Trainings are an agency wide deliverable – attendance. Monthly internal trainings and external training opportunities.
34. Our agency has an excellent schedule of courses, which provide us with CEUs at no cost. The training coordinator is very responsive to suggestions from team members.
35. Staff development receives requests from all and develops training based on needs. There is always education offered at lunchtime for convenience.
36. I have not made any yet, but I have attended trainings that were being held due to an employee request.
37. I have been to many different and interesting trainings!
38. N/A – non-clinical.
39. Monthly meetings to discuss needs and concerns, also solutions.

40. I am a new employee – any questions I need answered – are completely answered.
41. Computer training – Excel training.
42. We have a person on staff that helps us find tools that allows you to grow at your own pace.
43. Proactive approach to additional training by scheduling one-on-one meetings with key individuals.
44. When I adequately give justification for my request. Frivolous requests are rejected.
45. EBP – for children. Increased staff expertise in autism spectrum, trauma and dual disorders.
46. Requests for coverage of offsite training are always addressed. The annual CEU financial support (\$150) is substandard, not competitive, not realistic, and clearly not supportive of intra-national collegiality.
47. Approval and funding according to allowance per therapist, has been given routinely. “Topics of interest” information is routinely requested with follow-through as possible.
48. Have not had any requests for the agency yet.
49. Staff input is valued and sought.
50. There are a lot of trainings offered and a lot of others we are informed about. However, there could be more options applicable to working with children and their family.
51. Requests are usually granted to attend outside programs that are applicable to your job.
52. Agency has annual training survey and employees give feedback – we have requested more on GLBT issues and haven’t seen much for this, however, many times suggestions are responded to quickly.
53. We can make our own arrangements through a computerized website. Very easy to use.
54. They pay for up to \$150 – in outside trainings per year. They have always approved my requests and encourage on-going training strongly.
55. They provide an on-line education program and any time I requested approval for a training it has been a fast turn around.
56. Overall need for addiction training and viewing family system as affected as substance abuse/dependence and appropriate interventions.
57. Our training offerings are rich and plentiful. (Other commentary here was illegible).

2. Does your agency provide training in recovery philosophy?

<u>Yes</u>	<u>No</u>	<u>No Answer</u>
143/179	7/179	29/179
80%	4%	16%

1. N/A to my job.
2. ?
3. N/A
4. I don’t know what you mean.
5. What is this? Can’t give accurate answer because I don’t know.
6. Not sure what the question means.
7. Don’t know what this means.
8. N/A to my position.
9. Unsure.
10. ?
11. Don’t know.
12. I don’t know.
13. Unsure what is meant by “recovery philosophy.” We do use Stages of Change Prochaska “Methodology.” We certainly aim towards helping clients recover.

14. ?
15. N/A
16. Don't know – at least not in the program I work in.
17. N/A – non-clinical.
18. N/A – member of support staff.
19. Not sure what you mean by recovery because I work with children.
20. N/A
21. N/A – non-clinical.
22. Mostly used in adult services.
23. Extensive IMR training.
24. "Recovery" focus is a consistent theme. Focus, but more with adults, in kids we focus on strengths and risk-protective factors.
25. IMR and other shared decision-making training.
26. Don't know.
27. Is this an adult orientation philosophy? Working with children/adolescents recovery from what?
I am being a bit _____ as there are some things children/adolescents can recover from.
28. Not sure.

3. In helping people with mental illness establish a recovery oriented treatment plan, do you find your agency supportive? (Give examples)

<u>Often</u>	<u>Sometimes</u>	<u>Seldom</u>	<u>No Answer</u>
141/179	13/179	0/179	25/179
79%	7%	0%	14%

1. This agency puts the client first, will adapt services to meet clients' needs – especially those dealing with anxiety – incoming to agency for services.
2. Not a clinical, I can't respond to this.
3. Both administrative supervisor and LICSW supervisor, as well as other staff have helped me to figure out how to be comprehensive, yet concise in treatment planning and how to make sure goals are measurable and appropriate.
4. N/A to my job.
5. The clinicians focus on recovery plans for their patients and set smaller, easier goals for them to reach to lead to recovery.
6. Team coordination between providers.
7. That is only primary framework.
8. N/A
9. ?
10. N/A
11. Not sure.
12. Case management services and home services.
13. Treatment plans are recovery oriented with the client's goals as objectives.
14. Not applicable to my role.
15. This model has been more applied to adults than kids and families, so I am reporting based on that.
16. Groups are always being held – DBT, Anger Management, nutritional and so on.
17. Utilizing IMR individual/group and targeted case management.
18. Good used of evidence based practices.
19. N/A to my position.

20. We offer FCSS and have a LADC on site to help clients transition.
21. If clients need assistance with medication adherence they are given various locations in which to meet this need.
22. This agency almost wrote the book on recovery model of treatment. That's all the focus on when planning with clients and family.
23. I think.
24. We do support/foster interventions which aim to identify best healthy outcome given a clients level of illness and life circumstance.
25. Through supervision.
26. Focus on client centered goals and symptom management philosophies relative to performance of objectives established to complete/obtain goals.
27. We provide onetime orientation but also it is discussed in supervision.
28. Made changes to forms to include client language/preferences. We have started Webinar series with P. Deegan. Shared decision making – discussed in orientation.
29. ?
30. Treatment care levels appropriate to individual's needs – group team with providers – IPS options.
31. I am an office/administrative staff member but am exposed to the concept of recovery-based philosophy daily.
32. Client-centered goals, job support, use of medication planners, daily living skills training and support.
33. Goals are set immediately and referrals made to both in-agency and community resources.
34. Each person has a treatment plan, and it is reviewed by each client to help them move ahead in their life, e.g., if a client has difficulty taking meds then they are referred to medication clinic daily or 2 times per week, etc., where they can be monitored frequently. If improvement noted, then hours will be adjusted.
35. Goal oriented.
36. N/A – member of support staff.
37. N/A
38. Encouraged to use IMR. Seen wonderful progress using this tool. Supervisors provide all support needed.
39. Work with children – N/A.
40. N/A
41. N/A – non-clinical.
42. In children's we refer more to resiliency.
43. Agency's focus is on recovery. Providers of care are trained in this approach – as it follows that recovery oriented treatment plans are supported.
44. Cite goals and objectives for treatment in context of improved behavioral change that family desires. Home and community focus with cost management.
45. For Child and Adolescent Department the focus is usually fostering resiliency, though recovery can also pertain. Training in treatment planning has been provided, and follows agency policies and procedures. Built into the language of the treatment plan is the client (parents for children/adolescents as well as child) statement of recovery/resiliency from which goals and objectives are developed.
46. Based on training about our continuity of care.
47. Encouraged to see people as individuals, not as a disease. IMR strongly supported. Other training opportunities available that are recovery oriented.
48. Have not done so enough to respond to the question.
49. Clients are given follow-up appointments with a specific treatment team that has the appropriate expertise.

51. Yes, offer many services to facilitate psychotherapy - like supportive employment, skills training groups, and housing outreach teams.
52. I work at front-end call center, but from the feedback I hear from past clients or clients being referred to us by other practices, it's always been positive about the services we provide.
53. The recovery model is strongly emphasized. Whenever I need help developing a plan, it is always available.
54. Recovery is a part of the center's mission statement and a part of our principles and values.

4. Do you find services are truly based on consumer needs and interests?

<u>Often</u>	<u>Sometimes</u>	<u>Seldom</u>	<u>No Answer</u>
144/179	23/179	0/179	12/179
80%	13%	0%	7%

1. Services are based on the individual client's needs, which are carefully determined by a very thorough intake process.
2. What is research-based or a promising practice, "consumers have choices." The agency even makes the services of a naturopathic doctor available.
3. We target each client individually based on specific needs.
4. N/A
5. Unknown.
6. ?
7. N/A
8. Often times client needs require more time than clinicians can get paid for.
9. Parents need parenting therapy groups held without client present, especially if younger children and some funding sources won't reimburse – we are developing grants.
10. N/A to my position.
11. There are services clients want/need that we have closed (Gemini).
12. I believe the staff offers exceptional, professional and compassionate services to our clients.
13. Always.
14. N/A – non-clinical.
15. N/A - non-clinical.
16. Yes, the services provided include case management, treatment of behavioral/mental disorders addresses needs – re: symptom management/improved functioning. Case management can address both needs and interest.

5. When you represent consumer requests/needs to your agency staff, are they responsive? (Give examples)

<u>Often</u>	<u>Sometimes</u>	<u>Seldom</u>	<u>No Answer</u>
138/179	23/179	0/179	18/179
77%	13%	0%	10%

1. I have found that sliding scale and free care will be provided for those with needs but lacking financial resources.
2. Development of groups related to client goals.
3. Switching therapists, for example, male to female, as requested.

4. N/A to me – not a clinician.
5. In supervision, TEAM, and DBT consult, team members are responsive with support, suggestions, and resources.
6. If the client feels he/she needs more time, this is always looked into.
7. Clients wanted hand sanitizer for the waiting room. The next day there were 2 bottles in the waiting room.
8. Suggestion box checked frequently and requests given to Program Director.
9. The staff goes above and beyond to make sure the patients are stable and get what they need.
10. Prompt with answers.
11. Multiple sources for group: Referrals, Supported Employment IMR, DBT, etc.
12. Letters for pets, return to work, additional services as long as ethical and clinically indicated.
13. ?
14. N/A
15. Medication renewals, providing samples of medications, scheduling appointments.
16. At BCA I think the needs of the clients are considered, i.e., United Way Funding.
17. No, because the agency's hands are tied as to what we can provide due to restrictions in what can be billed.
18. Sometimes it is difficult to have case managers respond to client's need in a timely manner.
19. Medication requests are often met and applying for benefits are also aided by staff.
20. Yes – i.e., developing parts of service that can be more seamless (i.e., transfer of stable III (Level of Care) clients to med services.
21. Good collaborative work between consumers, clinicians and medical staff.
22. Yes, they listen and if the request can be provided it is done or alternatives are provided.
23. Referral to another program – seamless levels of care.
24. Scheduling flexibility complaints are responded to immediately.
25. N/A to my position.
26. Unsure.
27. This depends on the staff person you are dealing with.
28. Clients have been outreached with their medication if they were unable to come in due to medical condition.
29. The agency is dedicated to the consumer. When I am asked to plan a community activity the agency is fully supportive.
30. Immediately (IPS, supported employment, benefits, medications).
31. Implementation of In-Shape. Involvement in community garden.
32. N/A
33. N/A
34. Yes. Whenever I have had to contact a clinician regarding a client request, I have found them very responsive.
35. I.S. Department has priority field to enter filed client related requests.
36. If clients need a more flexible meeting time, "the agency" will look at changing available hours.
37. Each quarter, a report of surveys is sent to all staff, as well as any comments and changes.
38. N/A – member of support staff.
39. Turn around time under 24 hours – often within the hour.
40. Client needing to move to a higher level of care – referring a client to a co-worker for specialty services.
41. Some consumers request reduced fees – staff very responsive to help meet their needs.
42. Provide assistance guiding a client through financial aid maze.
43. Medical staff very open to consultations. Cases are often shared to benefit special consumer needs, i.e., separate family therapist.
44. Concerted effort is made to provide services according to consumer needs. These are thoroughly addressed in intake team meetings.

45. Changes in level of care, use of medication as part of ISP. Requests for change in therapist or treatment review.
46. Changing from office-based to home-based sessions. Need for more intensive services. Need for wrap-around services.
47. When I forward requests from the clients to the clinical staff they always have helped the client. I help the clients if I can within my job limits.
48. Have not done so enough to respond to the question.
49. Client asks for family meeting – the meeting is held.
50. Ad hoc committees, team and staff meetings/forums to discuss. Emails.
51. Our Emergency Services Department, as well as our individual counselors are always very responsive to our client requests. In the Scheduling Department, we outreach our counselors very often and they are quick to respond to our questions so we can quickly get back to our clients.
52. At times, clients have requested a change in clinician. In my experience, my supervisor and I talk with the client to explore the reasons for the request and to respond in clinically appropriate ways.
53. Start of two additional AA meetings in the evening on site. Expansion of emergency services to both Elliot and CMC.

6. Do you find an individual's services restricted by lack of funds? (Give examples)

<u>Often</u>	<u>Sometimes</u>	<u>Seldom</u>	<u>No Answer</u>
40/179	86/179	30/179	23/179
22%	48%	17%	13%

1. No, generally if someone needs a service it is provided for them regardless of their financial wherewithal.
2. Many patients who meet eligibility for services in the low utilizer category are limited in receiving needed services at MHCGM because of the \$4,000 cap. Vocational services have been restricted to a minimum for these patients and Evidenced Based Practices services i.e., IMR are not available to patients who qualify for services in the LU category. Our QI staff have applied to BBH for waivers allowing patients who need these services to receive them. The waiver was under review for 7 months and the results were a disappointment. Closing of Gemini House Program.
3. Closing of Gemini House. Lack of funding to hire adequate nursing staff. Restrictions on how much time we can provide necessary services to severely mentally ill. Slowing down of intakes to reduce overloading case loads when we can't hire more staff.
4. Clients who have no insurance are not turned away!
5. Our agency provides services such as identified in the treatment plan based on the individual client's needs. Unfortunately, due to inadequate reimbursement by insurance providers and the rise in uninsured that means taking a loss.
6. Some clients are unable to benefit from supported employment assistance.
7. I find this could become a future issue of services continue to be cut. How long can mental health centers continue to function with severe cuts and more consumers with no insurance?
8. Sometimes a client wants more of our time and we can't provide.
9. FSS caps. Gemini closing.
10. Due to funding issues we have had to close programs and limit services sometimes.
11. Recent budget cuts.

12. Certain services such as supported employment not accessible until client is at least pending Medicaid.
13. Gemini House closed because of funding restrictions (cuts). Pretty significant impact on vulnerable population!
14. ?
15. Transportation. Supplies/facilities. Activities/events. Vocational. MIMS. Staffing.
16. N/A
17. The cuts by the State as related to Medicaid are a major concern. Moving forward the Center does very well to manage these cuts, but there has to be a tipping point.
18. Not sure.
19. Extensive time it takes to get Medicaid authorized.
20. Insurances restrict services clients can receive, especially Medicaid clients. There are usually the clients that need the most services, and have the least coverage – 12 mental health sessions per year.
21. Patients who are 100% self-pay or have commercial insurance with co-pays sometimes choose and discontinue care to avoid debt.
22. Clients have no money and qualify for LU services but can't afford fees.
23. Medicaid individual psychotherapy reimbursement rates are about to get cut IN HALF – is this a trick question?
24. Yes, FSS services are only paid for Medicaid – other families have options for FSS provided a fee can be established. This can be a strain on families.
25. Gemini dual diagnosis residential treatment program closed due to state funding cuts. Individual billing hours and rates decreased by state funding costs.
26. Caia only services. We still provide if clinically necessary but are financially “punished” by reimbursers in doing so (the agency has to absorb the loss).
27. Clients are not able to go to our non-state funded programs from other departments if they do not have insurance.
28. Overall we are great at providing needed services, i.e., case management where no funding exists – to all clients regardless of funding!
29. Need for DBT group, insurance doesn't cover.
30. Uninsured clients that refuse to pay reduced fee are often asked to apply for Medicaid. This process can be extremely long, leaving the agency larger amounts of write-offs.
31. I think that would be evident by the state of our department.
32. If client does not have Medicaid they do not receive services through: vocational services, housing outreach team, limited services in med clinic.
33. Yes, by private insurance! Only allowing a certain number of visits.
34. Client to staff ratio has increased dramatically which decreases client access to clinicians.
35. There is never enough funding for clients or for staff salaries.
36. Due to clients having difficulty in obtaining benefits – it is difficult to help them meet their needs beyond mental health care.
37. N/A to my position.
38. Limited sessions.
39. Groups aren't offered because of regulations and funding concerns.
40. Increased difficulty with medication insurance issues – prior authorization or delay in coverage.
41. Presently, the agency has been cut back on funding which always affects the consumer.
42. Programs are cut – staffing bare minimum.
43. I provide treatment for the Medicaid population and these clients need and receive significant amounts of services. The only drawback is that each therapist has a large caseload so clients cannot always be seen on as regular basis as would be helpful.
44. Low utilizer cap, Medicaid cap, FSS cap, Medicaid rate reductions. We provide services but don't get paid.

45. Yes, the need to end Gemini House.
46. There are services that clients want (more leisure oriented trips, etc.) which are not necessarily symptom driven – more activity oriented – not reimbursable. Laps on services can impact community integration services.
47. N/A
48. N/A
49. Decreased funding does not allow necessary staff be hired to meet demands of care necessary.
50. Due to recent state budget cuts, there is an overall reluctance to spend money, “just in case” it gets cut more.
51. Not to my knowledge.
52. There are some services that have to be scaled back or allotted differently.
53. Currently, one of the houses closed due to decreased funding and utilization. This residence was one of the few in the state for mental illness and substance abuse issues.
54. Primarily only since the state started rationing care.
55. New caps make it impossible to provide all needed services to consumers, both one on one and group.
56. Medicaid and Medicare limits at times which restricts the clients’ sessions frequency.
57. N/a
58. N/A – non-clinical.
59. We see cases based on medical necessity, not funding. We treat uninsured people as well as insured.
60. Length of stay is carefully monitored in supervisor and team meetings. This sometimes conflicts with consumer desire for longer treatment stays.
61. Difficult to assign cases to non-licensed staff. Providing case management when managed care not covered. Insurance limits and high co-pays are hard on some families and staff.
62. Difficult recruitment, due to low reimbursement – lower pay scales. Cap on case management means decreased services for needy individuals.
63. Assistance with medication monitoring by wellness RNs dictated by insurance coverage.
64. There is no funding resource in almost every case that needs the services of a trained and certified behavioralist (ABA trained). Session numbers restricted under managed care insurers.
65. Lots of people are struggling financially, but really need services.
66. Not part of my job – I would not know an answer to this.
67. Not enough money for LU limited – no transportation services – minimal resources.
68. Those families with private insurance do not have access to some services (FSS) as easily, due to cost.
69. Clients are admitted without regard for their insurance or ability to pay.
70. Cannot refer to FSS, SE, groups and substance abuse treatment without insurances/funds, no transportation, cannot afford meds, limited inpatient options.
71. Not qualified to answer.
72. Auxiliary services are only covered by Medicaid. There are private-pay clients who would benefit, but can’t afford them. Primary treatment, however, has been provided consistently.
73. Medicaid clients who do not meet eligibility have a cap and it is encouraged not to see them too often.
74. The Center had to close Gemini House. Medicaid limitations have limited our ability to expand intake and clinicians services resulting in increasing worst of times.

7. Are your agency's managers accessible to you?

<u>Often</u>	<u>Sometimes</u>	<u>Seldom</u>	<u>No Answer</u>
163/179	11/179	1/179	4/179
91%	6%	1%	2%

a. Are your supervisors accessible to you?

<u>Often</u>	<u>Sometimes</u>	<u>Seldom</u>	<u>No Answer</u>
167/179	8/179	0/179	4/179
93%	4%	0%	6%

b. Do you find managers/supervisors helpful when you have questions, problems, or ideas that you wish to discuss?

<u>Often</u>	<u>Sometimes</u>	<u>Seldom</u>	<u>No Answer</u>
159/179	16/179	0/179	4/179
89%	9%	0%	6%

7. Are your agency's managers accessible to you?

No comments.

a. Are your supervisors accessible to you?

No comments.

b. Do you find managers/supervisors helpful when you have questions, problems, or ideas that you wish to discuss?

1. My supervisor is stretched very thin, covering multiple programs, but I can always find a supervisor or manager who is available when needed. Responsibilities are willingly shared by a very cooperative administrative staff.
2. Often times they don't want to hear things that are outside of their restrictions, especially from Medicaid as their hands are tied.
3. They are always willing to listen, discuss and consider new ideas.
4. Always responsive when they have resources to work with.
5. Feel very supported, challenged and big focus on my professional development.
6. Very little feedback on suggestions.
7. Always.
8. Have never had a problem accessing assistance in a timely fashion.
9. I am a manager/supervisor.
10. Always feel valued and supported, both personally and professionally.

Additional Comments:

1. This survey changes direction from poor---good, then, often ---seldom – a little confusing.

2. A very supportive team at this agency, including the administration that is very open and honest with staff about developments and challenges within the agency – a real team approach that recognizes and values its employees – very unusual – and it is appreciated!
3. The team is very supportive and provides a good resource to help manage large caseloads and complex clients. My supervisor fosters this approach.
4. As I noted above, I foresee, it will be a challenge to serve the growing population of clients without insurance and funding, if services continue to be cut.
5. Great employer – great center for clients.
6. This agency is quite responsive to both employee and client needs, but is constantly changing and struggling with all of the expectations demanded.
7. Great employer and a great agency for clients to receive services.
8. MHCGM is a great company to work for. We really believe in helping the clients!
9. Excellent staffing and management team.
10. Best mental health agency – in 5 states!
11. Glad to be part of the team.
12. Being support staff, I do not see the many services offered to our clients through the clinical staff. I do, however, see the results of these services in the clients as they continue treatment: they are very eager to express how much their clinician/medical prescriber has done for them.
13. I find the Mental Health Center of Greater Manchester to be on the cutting edge of community mental health treatment and I believe is the best in the state.
14. I think the agency does care about the clients we serve. This shows on most levels.
15. I would not want to work at another community mental center. I really love working here.
16. I believe the Mental Health Center of Greater Manchester is doing a very good job to support the community in all of its mental health needs. I feel valued and supported as an RN employee.
17. It's been a pleasure to work here.
18. Our agency is very oriented to patient care and treatment as well as very supportive to staff training and teamwork.
19. This is an outstanding agency both from an employee perspective and from a client's perspective. I have clients who travel from the seacoast and Massachusetts to access care here.
20. I feel the agency is very professional in its approach to both staff and clients.
21. It was difficult to give accurate answers as I am an intern and have only been at this site for 4 months.
22. There is a strong need for groups (i.e. parenting, anger management), but there seems to be barriers around confidentiality and payment procedures that prevent these from happening.
23. Our leadership/managerial staff are excellent at their jobs and are focused on excellence throughout the agency.
24. My agency is excellent in supporting clients and employee needs to cooperatively minimize the effects of mental illness on client's lives.
25. I am very proud to work for this agency and work with such a talented, trained and committed group of co-workers and managers.
26. The agency is wonderful to all employees. The leadership has respect for all who work here. They take ideas from all when decisions need to be made.
27. The Mental Health Center of Greater Manchester is a wonderful agency to work for. Supervisors and directors are always available and receive employee feedback with interest and respect. It is a pleasure to work for an agency that cares very much about their staff and have great respect for the work we do.
28. Generally speaking, this agency, after some comparison, is doing a far better job of providing supervision, support and services. Within my department there is a strong sense of purpose that is supported by policy and procedure. Our values and ethics are something to be proud and thankful for as an employee and as a clinician.

29. This agency works diligently under very difficult economic times to continue to provide quality care to all.
30. I find MHCGM a great place to work. I think the staff feel valued and supported and work hard to provide the best quality care to all clients.
31. The agency provides an extensive amount of programs, training, continued education for all levels of staff. This includes onsite, classroom, seminars and webinars.
32. Agency is remarkable for its openness and availability of program directors and supervisors.
33. Salary parity and transparency are both lacking. Overall, MHCGM is very considerate of its employees' contributions and expertise.
34. MHCGM, and in particular, the Child and Adolescent Department where I work, provide high quality services to consumers. There is sincere, active commitment to our mission statement throughout the agency. Agency senior leadership and department managers and coordinators also provide employees with the tools and supports to meet and even exceed expectations. I very much appreciate the opportunity to work in a validating environment that strives for excellence. This highly professional approach really does facilitate my own ability to provide the very best service I can in the work I love.
35. No more cut backs. Consumers and employees are really struggling.
36. I am in a non-clinical job within the agency. I find the job to be fulfilling and my co-workers and supervisor to be helpful and supportive to the agency's mission.
37. Most of my clients do not care about having long-term goals nearly as much as the Bureau does. Paperwork requirements are at a level that is beginning to become a barrier to treatment.
38. I am proud to work for the MHCGM. The agency promotes recovery-based interventions for clients and is extremely supportive of staff. This is a stressful job and I am always grateful for the support I get to be able to do my job well and to improve my skills as a clinician. We provide extensive services and I feel privileged to be part of an organization that cares so much.
39. Increased quality assurance requirements/paperwork have, from what I hear from colleagues, decreased morale. Subtle increased work expectations and accompanying decreased revenue resources in past decade - for example my real income has decreased by 100%. Because I believe in original ____ of community mental health, I am committed, but...where is the real community in community mental health? A philosophy supplanted by other questionable or at least a case for challenging. Now it seems all about money – not the client. This is a survival mode – not progressive/cutting edge.
40. I am concerned re: state budget cuts and the adverse impact on our agency and that will impact client care. If the state keeps cutting the money, I am concerned that we will lose some of the important services that we offer.
41. Supervision is regular, focused on my individual development plan as well as on strategies to improve client care.

SECTION IV: POLICY

Policies and procedures ensure that fundamental organizational processes are performed in a consistent way that meets the organization's needs. Policies and procedures can be a control activity used to manage risk and serve as a baseline for compliance and continuous quality improvement. Adherence to policies and procedures can create an effective internal control system as well as help demonstrate compliance with external regulations and standards.

The MHCGM BOD is ultimately responsible for establishing the policies for the governance and administration of the CMHP. Policies are developed to ensure the efficient and effective operation of the CMHP. The BOD, through a variety of methods, is responsible for demonstrating adherence to the requirements of state and federal funding sources.

At the time of the review MHCGM was in substantial compliance with all the requirements referenced above.

REQUIREMENTS:

He-M 403.05 (e) A CMHP Board of Directors shall establish policies for the governance and administration of the CMHP and all services through contracts with the CMHP. Policies shall be developed to ensure efficient and effective operation of the CMHP-administered service delivery system and adherence to requirements of federal funding sources and rules and contracts established by the department.

OBSERVATIONS IV-A:

Policies and procedures were found in a variety of locations including a policy manual, a fiscal manual, an employee handbook, and an orientation manual. The format of these documents varied with some, including both ED and BOD signatures, while others may not have included both or either signatures.

RECOMMENDATIONS IV-A:

It is recommended that a comprehensive policy manual be developed, reviewed, signed and dated by the BOD, or that a policy be developed allowing the BOD to appoint a designee as responsible for approval of policies.

CMHP RESPONSE IV-A:

OBSERVATION IV-B:

There are specific written and unwritten billing procedures that are available for the staff. There are a few financial policies that the agency should consider incorporating in order to strengthen the internal controls of the agency.

RECOMMENDATIONS IV-B:

It is recommended that all policies, including financial, be consolidated in one policy manual. The agency should consider developing the following written policies:

- Differentiating between capital expenditures and repairs;
- Requiring written approval for non-recurring journal entries;
- The use and accountability of credit cards including the supervising of any ED's expense by the Board;
- Outlining the budget process;
- Requiring two signatures on checks in excess of a certain amount (as determined by the BOD).

CMHP RESPONSE IV-B:

GENERAL OBSERVATION IV-C:

Several policies and program descriptions still refer to Mental Illness Management Services (MIMS) including:

Policy No. 10.11.02 MIMS Services Billing Arrangements;
Policy No. 3.01.05 Deaf Services;
Policy No. 3.01.05 Senior Counseling Services;
Policy No. 10.11.01 Insurance Verification/Authorization.

RECOMMENDATIONS IV-C:

Update and or delete policies that include references to discontinued services such as Mental Illness Management Services.

CMHP RESPONSE IV-C:

SECTION V: FINANCIAL

The purpose of financial oversight and monitoring is to ensure that public funds contracted to the CMHP are managed according to all applicable statutes, rules and regulations. Self-monitoring of a CMHP not only helps ensure the integrity of the single agency but the statewide mental health system. An insolvent CMHP cannot attain its Mission.

An essential role of a BOD is fiduciary oversight. In order for a CMHP BOD to be able to meet its fiduciary responsibilities to the State and the people it serves, several things must occur. The BOD often has a Finance Committee that assists with the development of the yearly budget and reviews monthly financial statements, yearly audits and other information. In addition, the Finance Committee and the CFO share information with the rest of the BOD. Discussion of these issues should be well documented in the monthly Board minutes.

It is essential for any CMHP to have a comprehensive Financial Manual with policies and procedures that guide the day-to-day operations of the CMHP. Ongoing monitoring for compliance with internal control policies and bylaws is essential. In addition, there should be ongoing internal monitoring of financial and billing systems in order for an agency to remain solvent. Documentation of these internal controls is also essential.

The purpose of financial oversight and monitoring by the State Mental Health Authority is to review the financial performance of the CMHP. Best practices that serve to enhance the system as a whole through continuous improvement are also identified.

Please note that the format of this section differs from the remainder of the report. This is due in part to He-M 403 not including most financial areas addressed during the reapproval review. Some of the areas below are addressed in BBH contract and others are general comments and best business practices.

At the time of the review, MHCGM was in full compliance with all the requirements referenced above.

OBSERVATION V-A:

During FY09, MHCGM's Accounts Receivable older than 212 days has increased for private consumers. During FY08 this amount was \$90,077, and at the end of FY09 this amount had increased to \$157,260.

RECOMMENDATION V-A:

MHCGM is encouraged to monitor any growth in Accounts Receivable older than 212 days. Any receivables that are deemed uncollectible should be written off.

CMHP RESPONSE V-A:

SECTION VI: QUALITY IMPROVEMENT AND COMPLIANCE

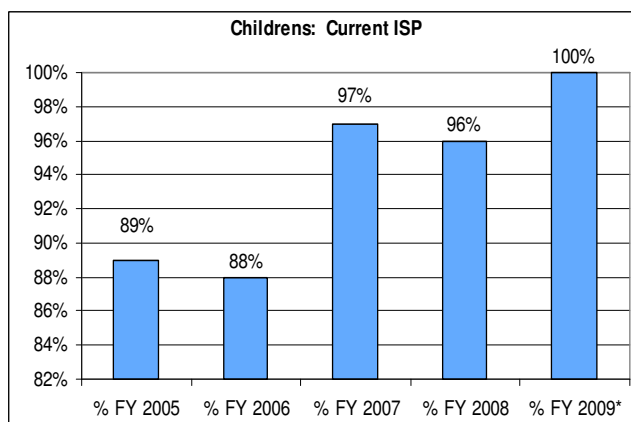
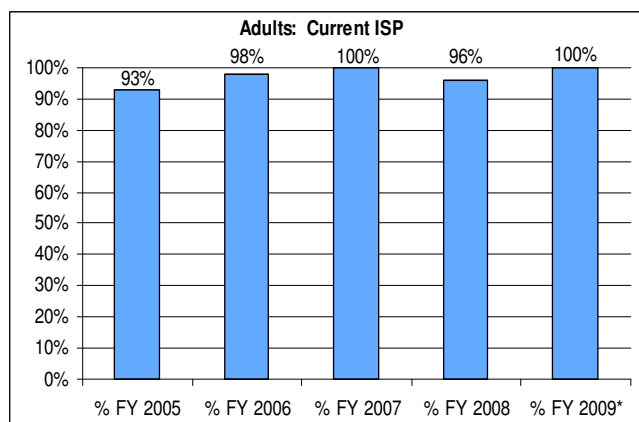
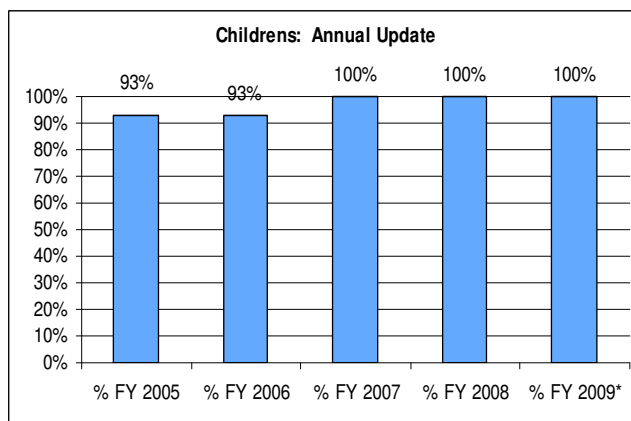
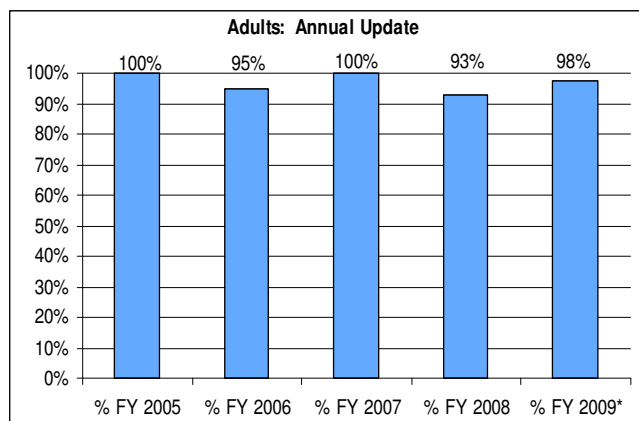
Quality improvement and compliance activities are expected to be conducted on both the state and local level. The BBH conducts annual quality improvement and compliance reviews and CMHP reapproval reviews on a five-year cycle. Other reviews occur as needed and requested.

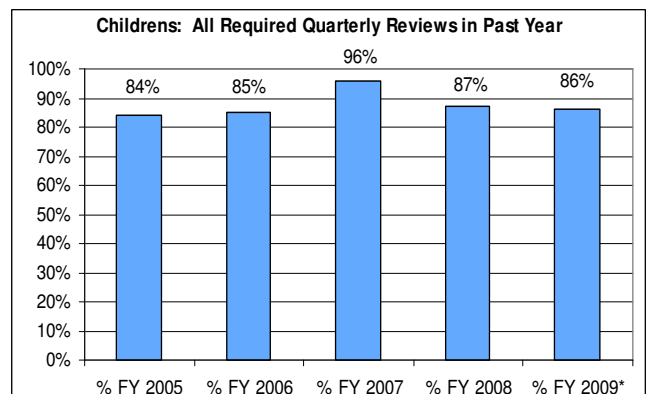
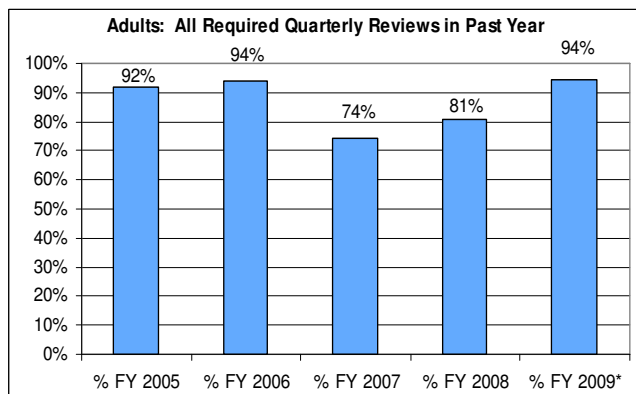
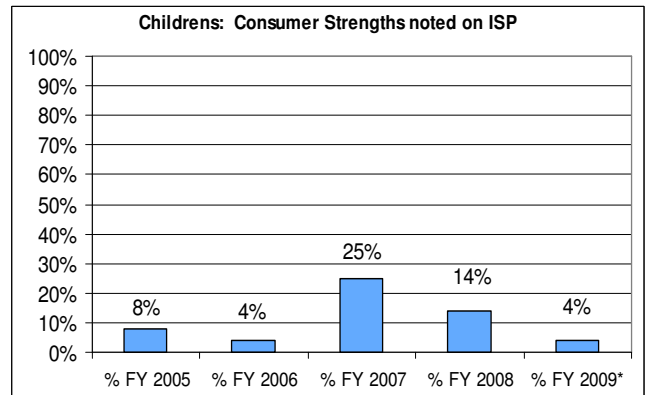
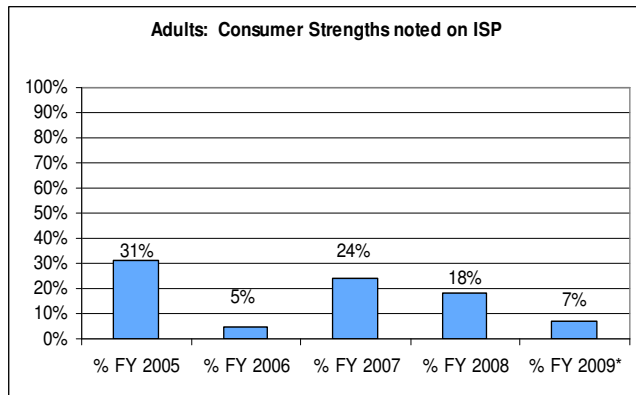
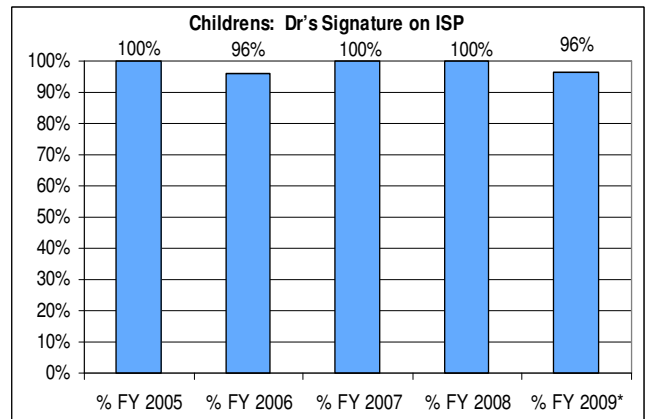
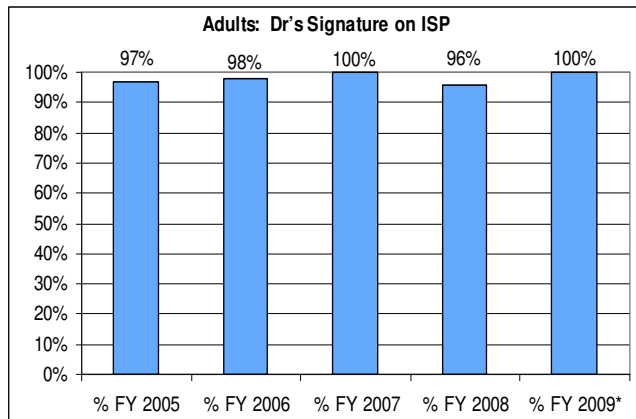
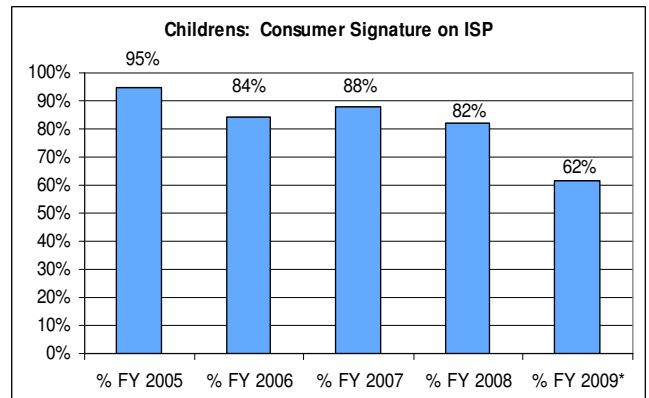
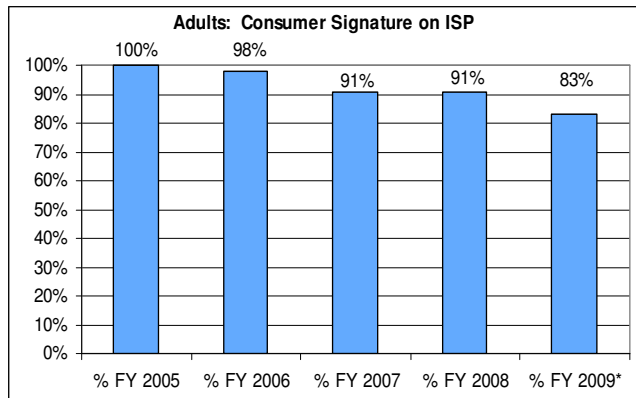
He-M 403.06 (i) and (j) outlines the minimum requirements for CMHP quality assurance activities. These include a written Quality Assurance Plan which includes outcome indicators and incorporates input from consumers and family members. The annual plan is submitted to BBH. Other activities include utilization review peer review; evaluation of clinical services and consumer satisfaction surveys. Please see the findings below regard internal CMHP quality improvement and compliance activities.

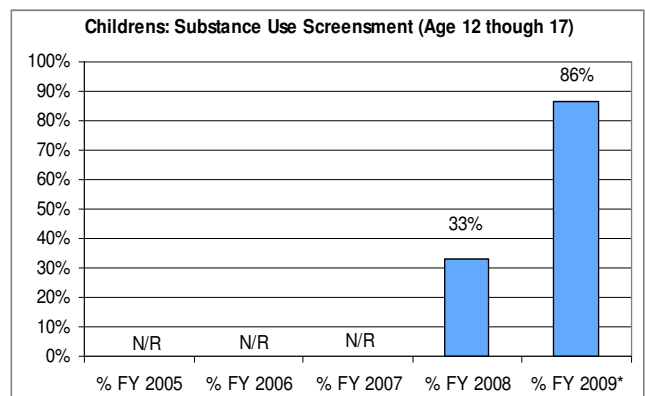
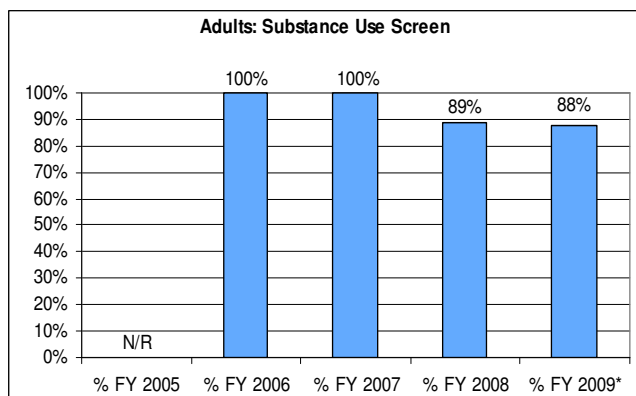
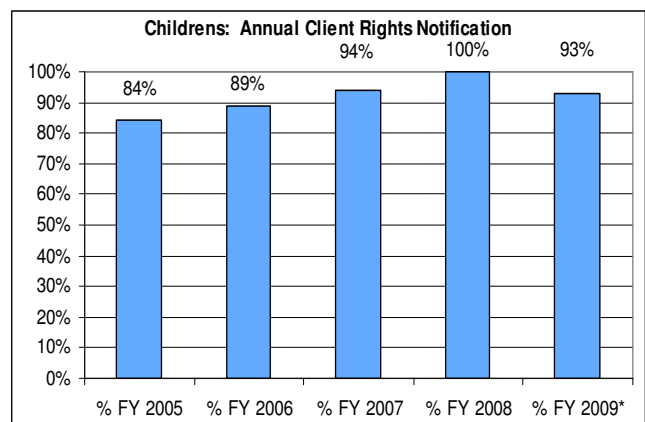
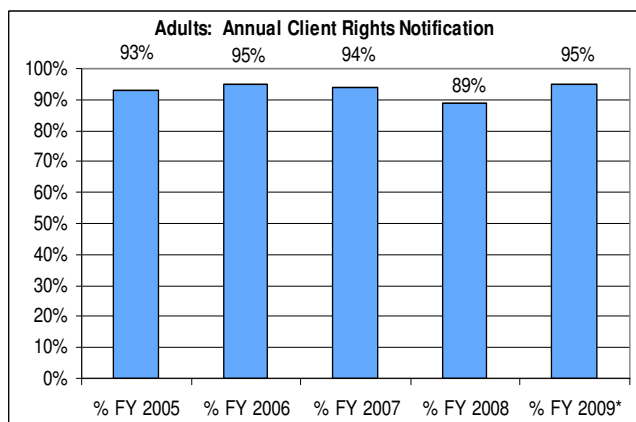
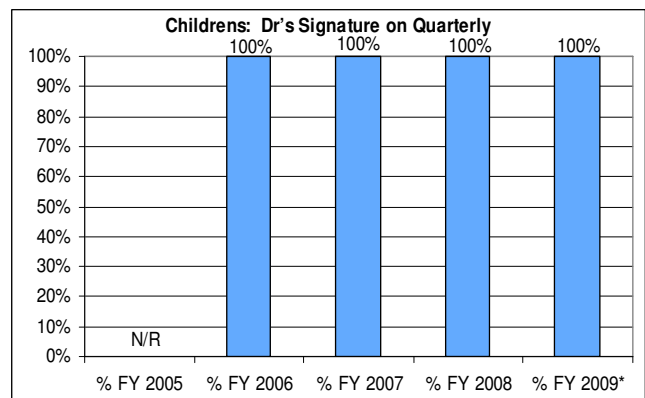
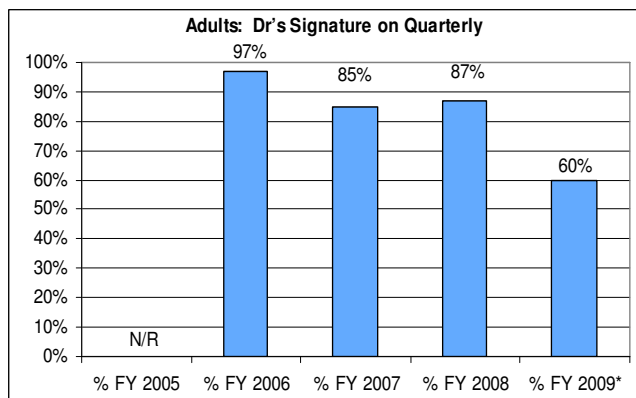
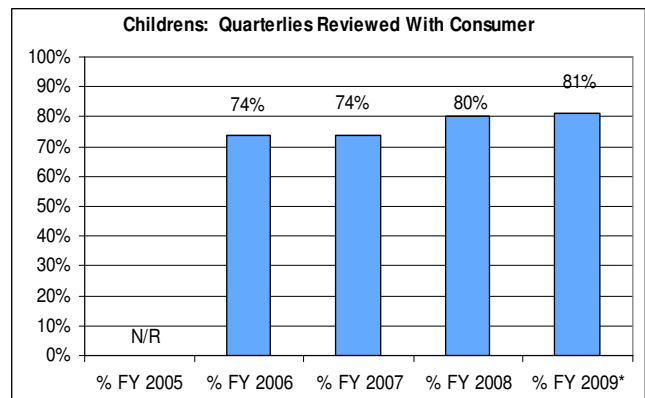
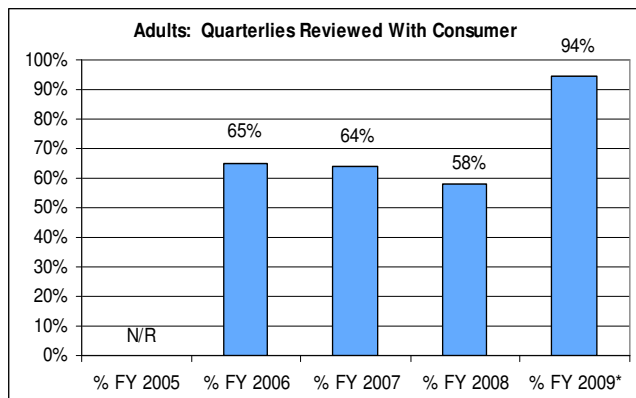
At the time of the review, MHCGM was in substantial compliance with all the requirements referenced above.

OBSERVATION VI-A:

Five-year trend data from the annual BBH quality improvement and compliance reviews has been included as an overview of the MHCGM level of compliance with clinical record standards. The charts below reflect some of the clinical record requirements and MHCGM compliance levels. “N/R” noted in the charts below indicate that this requirement was not reviewed in a given year. In recent years BBH has requested corrective action plans for any area with a compliance rating of 75% or less. These corrective action plans are received as part of that annual process.







RECOMMENDATIONS VI-C:

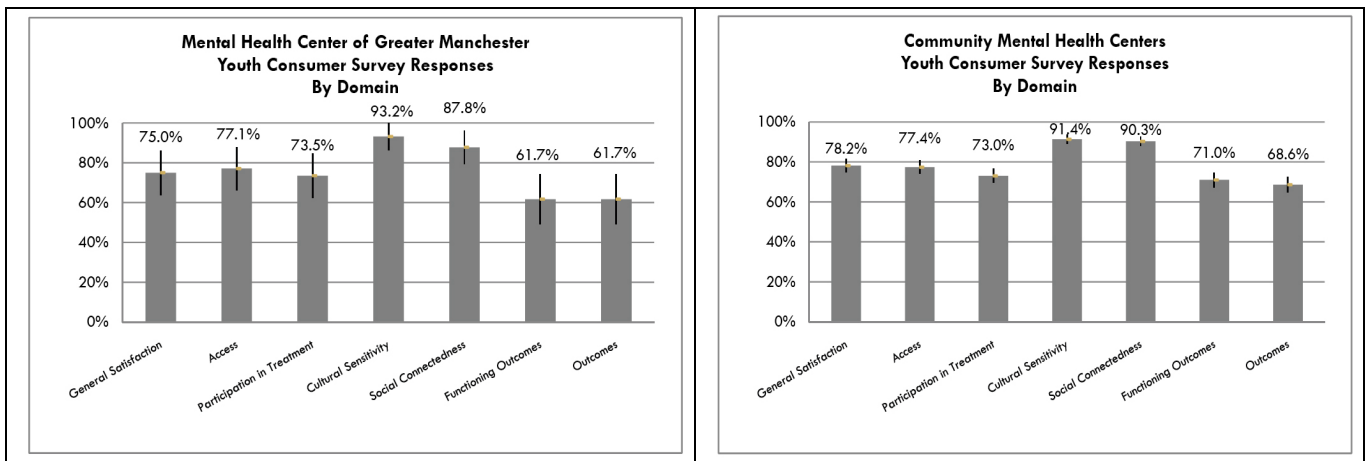
It is recommended that the BBH QI and Compliance Reports be shared with the BOD and utilized in planning activities. It is also recommended that MHCGM continue to conduct and document internal quality improvement and compliance activities.

CMHP RESPONSE VI-C:

SECTION VII: CONSUMER AND FAMILY SATISFACTION

In the fall of 2007, the NH DHHS, BBH contracted with the Institute on Disability at UNH to conduct the NH Public Mental Health Consumer Survey Project. The project is part of a federally mandated annual survey of the nation's community mental health centers. The IOD and the UNH Survey Center conducted and analyzed findings for a consumer satisfaction survey of youth (ages 14 through 17), adults (ages 18 years and older), and family members of youth (ages 0 through 17) receiving services from NH's ten community mental health centers.

Below are summary excerpts from reports for both MHCGM and the ten CMHPs as a group. Data from the surveys was compiled into seven summary categories including: General Satisfaction, Access, Participation in Treatment, Cultural Sensitivity, Social Connections, Functioning Outcomes, and Outcomes. The charts are divided by population into three sections including: youth, adults, and family members of youth.



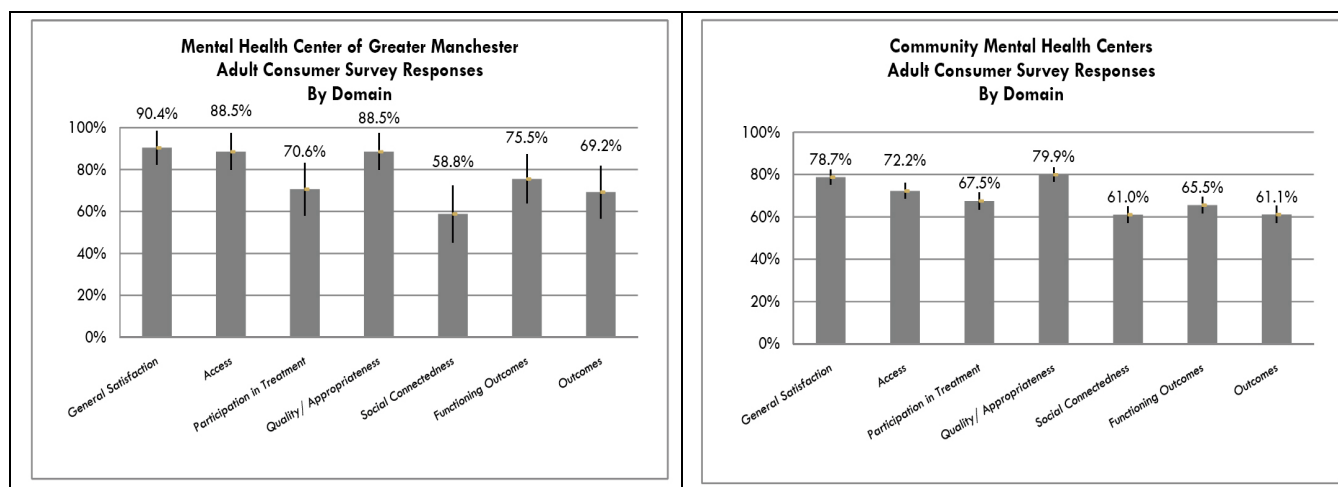
OBSERVATION VII-A:

It is noted that MHCGM percentages ranked below the statewide average in the following Youth Survey domains: General Satisfaction; Access; Social Connectedness; Functioning Outcomes, and Outcomes.

RECOMMENDATIONS VII-A:

It is recommended that the NH Public Mental Health Consumer Survey Project be shared with the BOD and utilized in planning activities.

CMHP RESPONSE VII-A:



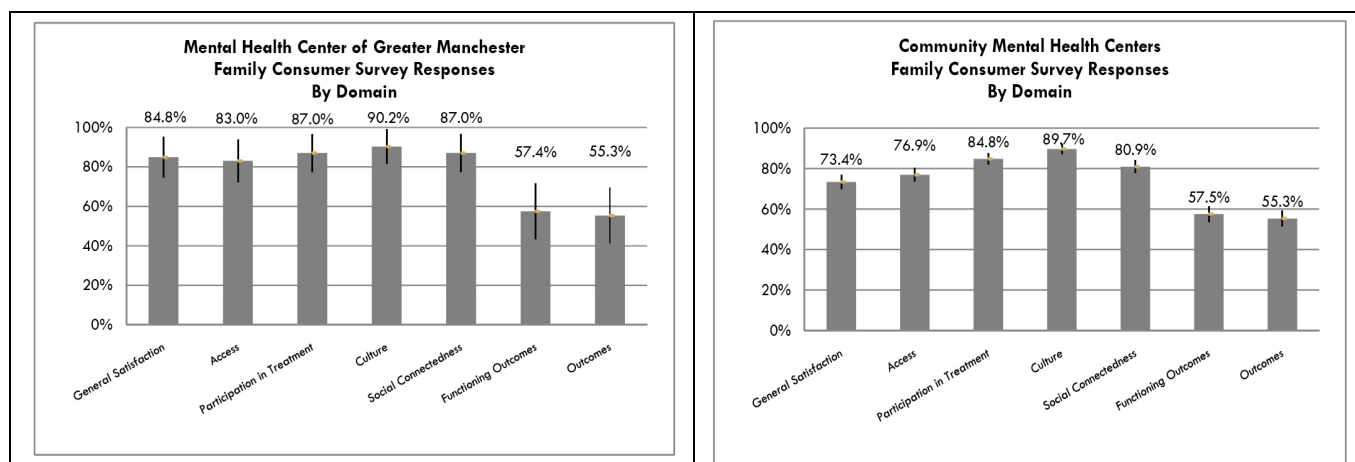
OBSERVATION VII-B:

It is noted that MHCGM percentages ranked below the statewide average in the following Adult Survey domain: Social Connectedness.

RECOMMENDATIONS VII-B:

It is recommended that the NH Public Mental Health Consumer Survey Project be shared with the BOD and utilized in planning activities.

CMHP RESPONSE VII-B:



OBSERVATION VII-C:

It is noted that MHCGM percentages ranked below the statewide average in the following Family Survey domain: Functioning Outcomes.

RECOMMENDATIONS VII-C:

It is recommended that the NH Public Mental Health Consumer Survey Project be shared with the BOD and utilized in planning activities.

CMHP RESPONSE VII-C:

END OF REPORT